Patient Name:_____

DOB:_____ Wt(kg):_____

Allergies:_____ Phone:_____

Injectafer (Ferric Carboxymaltose) Infusion Orders

Required Information:

- ☐ Signed order from prescribing provider
- ☐ Patient demographics including insurance information
- ☐ Supporting clinical documentation: Visit notes, diagnostic results

Primary Diagnosis:

- ☐ Iron deficiency anemia (ICD-10 :_____)
- ☐ Other:_____(ICD-10:_____)

INJECTAFER ORDERS

- ☐ **<50kg:** Injectafer 15mg/kg on day 1; repeat dose after at least 7 days
- ☐ **≥50kg:** Injectafer 750mg on day 1; repeat dose after at least 7 days
- ☐ Other: Injectafer _____mg; frequency:_____

Administered per manufacturer guidelines

PRE-MEDICATIONS

- ☐ PO Tylenol _____mg
- ☐ PO Cetirizine _____mg
- ☐ IV Solu-medrol _____mg
- ☐ PO Loratadine _____mg
- ☐ PO ☐ IV Diphenhydramine _____mg
- ☐ PO ☐ IV Other:_____ _____mg

LABS

- ☐ CBC
- ☐ CMP
- ☐ CRP
- ☐ ESR
- ☐ TB Quantiferon Gold
- ☐ Hep B Core/Surface AG
- ☐ Uric Acid
- ☐ Other:_____
- ☐ Other:_____

Frequency:

- ☐ Every Visit
- ☐ Every Other Visit
- ☐ One time only
- ☐ Other:_____

CPL Acct #:_____

ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

_____

_____

_____

Physician Name:	**Phone:**	**Fax:**
Physician Signature:	**NPI:**	**Date:**